Division of Program Integrity Annual Report

SFY 2015 Annual Report

Department of Medical Assistance Services

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COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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Dear Fellow Virginians:

I am pleased to present the Virginia Medicaid Program Integrity Annual Report for State Fiscal Year 2015. Virginia Medicaid program integrity efforts are not limited to a single division in DMAS, but involve the entire agency and coordination with a variety of outside partners. This report is a compilation of the fine work of the staff of the Department of Medical Assistance Services (DMAS) and our many partners.

The Program Integrity Division (PID) is entrusted with the responsibility of ensuring the Virginia Medicaid Program is equipped to combat waste and abuse and refer potentially fraudulent providers and recipients to the proper law enforcement entity. Only a small percentage of Medicaid providers and recipients engage in various forms of fraud, but fraud and abuse affects everyone (the recipients of care, the taxpayers who pay for it, and the providers who provide quality care). Each dollar lost to fraud is one less dollar available for someone in need of care.

During SFY 2015, DMAS program integrity efforts proactively prevented $141 million and retroactively discovered over $27 million in improper payments. DMAS' managed care partners recovered or prevented an additional $12.1 million in improper payments. In addition, PID made efforts to expand fraud identification and prosecution, making 140 referrals of potential provider fraud. DMAS staff also worked with the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) to achieve fraud convictions of 45 providers. Finally, DMAS Program Integrity and Health Care Services Divisions continue to work with DMAS' managed care partners to enhance program integrity within their organizations as well as within Virginia Medicaid.

The attached report provides information about DMAS program integrity efforts during the 2015 fiscal year including statistical information, such as estimated savings and audit outcomes. I believe you will find this report helpful in gaining insight into the Department's program integrity activities.

Sincerely,

Cynthia B. Jones, Director
Department of Medical Assistance Services

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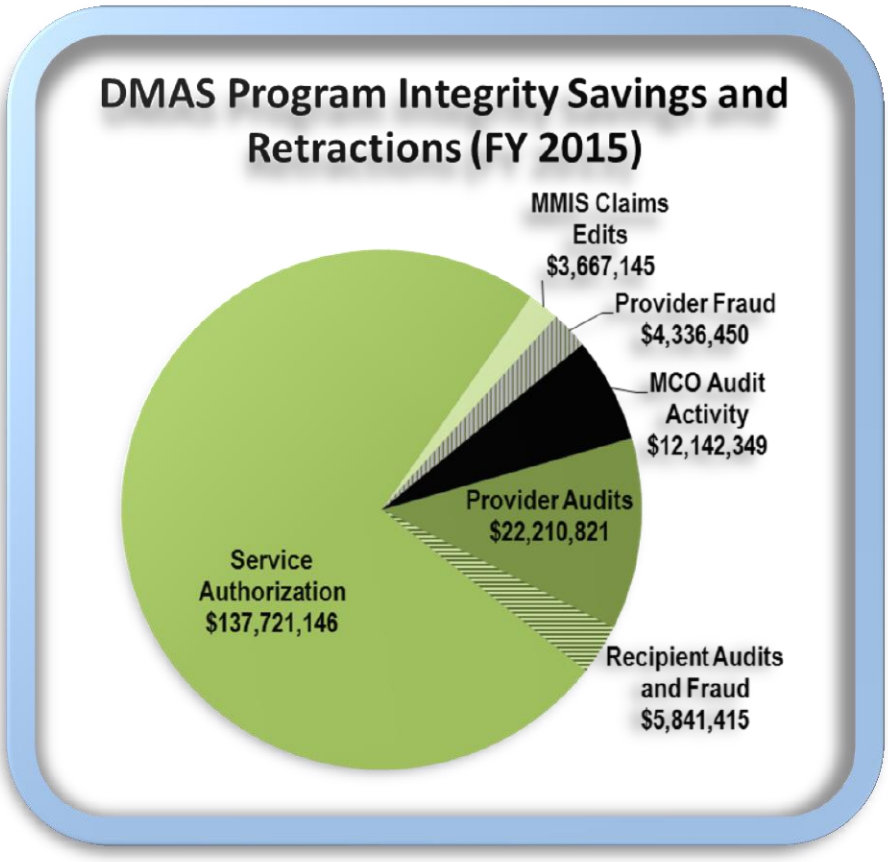
Executive Summary

Program Integrity (PI) is the collective term given to activities conducted by the Department of Medical Assistance Services (DMAS) to ensure taxpayers' dollars are spent effectively and appropriately. The mission of the Program Integrity Division (PID) is to protect the Medicaid program from external abuse and fraudulent activities, recover inappropriate Medicaid payments, and support the integrity efforts of the various Medicaid programs by offering oversight and technical assistance. The activities of PID are supported by the PI efforts of a variety of DMAS divisions as well as partner agencies to identify fraud and abuse. PID's program integrity activities are further supported by the integrity-related efforts of the Department's major national program integrity contracts, including a transportation broker, a dental and incontinence contractor, and a behavioral health service administrator as well as the integrity programs of each of the seven managed care organizations.

During SFY 2015, program integrity activities uncovered and/or prevented over $186 million in improper expenditures in the Virginia Medicaid program. The chart below provides a snapshot of program integrity savings in SFY 2015. A substantial portion of PI savings came from cost avoidance due to the service authorization process, which denies medically unnecessary service requests. While prevention is preferable, not all improper payments can be detected before payment occurs. To mitigate inappropriate claims that are not identified through prepayment processes, DMAS conducts a variety of post-payment audit activities to identify misspent funds. As a result, $27.6 million in identified recoveries is attributable to post-payment audits of providers and recipients conducted by Program Integrity Division staff and contractors. In addition over $4.75 million in restitution to the Medicaid program was ordered as a result of provider and recipient fraud convictions. DMAS managed care partner activity identified and/or prevented an additional $12.1 million from similar program integrity activities.



Program Integrity Overview

DMAS' PI efforts are summarized in four major areas:

- **Prepayment** efforts prevent improper expenditures through front-end controls that ensure that claims are only paid for appropriate and necessary services. These processes ensure that services rendered are medically necessary (Service Authorization), providers are eligible and enrolled in the Medicaid program (Provider Exclusion) and that claims are paid according to DMAS policies on allowed services and national medical billing standards(Claims Processing).
- **Payment Integrity** processes ensure DMAS identifies recipients who have other health coverage (Third-Party Liability) and that DMAS receives all of the rebates due from pharmacy manufacturers.
- **Data Analysis and Provider Selection** processes help DMAS to focus audits on areas where there is a high risk of overpayments. This ensures that program integrity resources are utilized in the most efficient and effective manner.
- **Post-payment** audits are conducted to identify claims paid improperly and recipients who are not eligible for the Medicaid program. By investigating referrals and reviewing medical record documentation, DMAS identifies improper expenditures and forwards potentially fraudulent cases on for criminal prosecution.

Preventing Improper Payments

Cost avoidance is the Department's first step in its PI efforts. Improper payment prevention also provides an additional deterrent to providers who knowingly submit inaccurate claims. Two major components of prepayment program integrity are the service authorization process and the Medicaid Management Information System (MMIS) claims processing system.

Service Authorization

DMAS requires providers to obtain prior authorization of the medical necessity of certain services (referred to as service authorization) before a claim can be paid through MMIS. DMAS contracts with Keystone Peer Review Organization (KePRO,) which allows providers to submit requests by phone or via the internet. KePRO medical staff review the information submitted by providers and determine if the service is medically necessary under DMAS policy. Service authorization avoided costs of over $137 million in SFY 2015.

Savings Type	SFY 2015 Denied Units/Days	SFY 2015 Savings
Inpatient Days Denied	2,301	$3,589,080
Outpatient Units Denied	303,602	$30,356,603
Outpatient Unit Reductions	1,014,024	$103,775,463
Totals	**1,319,927**	**$137,721,146**

Efficiency through Automated Requests

During FY 2015, DMAS worked with the contractor identify opportunities to improve the efficiency of the service authorization process. The contractor suggested that requiring all Waiver, EPSDT Personal/Attendant, EPSDT Private Duty Nursing, and Inpatient Acute providers to submit requests exclusively through their web portal would substantially streamline this process. The use of the Atrezzo web portal reduces time in both submission and processing, and also reduces error rates in the input of information, thus resulting in more accurate documentation. As 91 percent of providers already utilized the web portal, it appeared the impact of this policy change would be limited. In order to further ease this transition; DMAS is holding training sessions online and at a variety of on-site locations to introduce the web portal to providers who do not currently use it and to review portal submission methods, including the completion of questionnaires for specific services.

MMIS Claims Processing Edits

DMAS always has subjected claims to rigorous prepayment scrutiny through its automated claims processing and review system called the Medicaid Management Information System (MMIS). This system contains hundreds of edits that reject inappropriate or improperly billed claims. In June 2013, DMAS implemented the CMS-mandated National Correct Coding Initiatives (NCCI) edits to improve the prepayment claims review process. These prepayment edits prevented $3,667,145 in improper payments in SFY 2015.

Provider Screening Processes

Provider enrollment processes ensure the integrity of the provider network by reviewing the credentials of individuals applying to enroll as Virginia Medicaid providers. Enrolled providers are routinely reviewed, and unqualified or barred providers are terminated from the program. In the first quarter of 2014, DMAS became the first state agency in the region to implement enhanced provider screening requirements under the Affordable Care Act (ACA.) Effective March 31, 2014, DMAS now regularly screens both service providers and business owners against all seven required federal databases of banned and/or suspect providers. DMAS also conducts on-site screenings on all high-risk providers prior to enrollment or recertification. These additional provider enrollment measures help to prevent improper payments by providing more complete and up-to-date information on providers, and by assigning greater scrutiny to the enrollment of riskier providers. DMAS is currently in the planning phase for the implementation of the requirements for fingerprinting and background checks for providers designated as high risk.

Monitoring Recipient Pharmaceutical Utilization

Improper usage of pharmaceuticals by recipients presents both program integrity and quality of care issues in the Medicaid program. In particular, misuse and overuse of narcotics represent a major challenge nationally and in the Commonwealth. In order to mitigate this issue, DMAS has enacted several measures to monitor and manage recipients to ensure proper utilization of narcotic medications. Within the DMAS fee-for-service program, the DMAS Recipient Monitoring Unit analyzes and evaluates recipients to determine if they should be enrolled in the DMAS pharmaceutical management program. This program can involve assigning a recipient to a single prescribing physician and/or a single pharmacy to allow coordinated oversight of pharmaceutical usage.

In addition to this program, DMAS' managed care partners have implemented similar processes to manage and control pharmacy usage for members enrolled in their programs. In SFY 2015, MCO pharmaceutical management enrollment averaged 1,102 members. In order to encourage a coordinated effort to address pharmacy mis-utilization, DMAS worked collaboratively with its managed care partners to identify emerging issues and discuss possible approaches to address these issues. To aid members of this workgroup in identifying potentially problematic providers, DMAS engaged a contractor to analyze prescribing patterns in SFY 2014. MCOs utilized this analysis to identify more than 40 providers to audit in SFY 2015.

Recipient Eligibility Investigations

DMAS conducts a wide variety of activities to ensure the accuracy and integrity of the Virginia Medicaid recipient enrollment processes conducted by local Departments of Social Services and others. Post-enrollment audits are conducted to identify recipients who were improperly enrolled in Medicaid, as well as to uncover improper payments made on behalf of ineligible recipients. DMAS also collaborates with the Virginia Department of Social Services, the State police, and a new eligibility contrator to address recipient fraud and abuse, as well as enrollment accuaracy.

The Recipient Audit Unit (RAU) is responsible for the investigation of allegations of acts of fraud or abuse committed by recipients of the Medicaid, Family Access to Medical Insurance Security (FAMIS), and State & Local Hospital (SLH) programs. Typical eligibility issues uncovered in these reviews include deceit in the application process, illegal use/sharing of a Medicaid card, uncompensated transfer of property, excess resources or income, and fraudulent household composition. The investigations may result in the identification of misspent funds, administrative recoveries from recipients, or criminal prosecution. The unit also investigates drug diversion and performs joint investigations with various law enforcement entities (the Virginia State Police, the FBI, etc.), as well as the Social Security Administration, and other federal/state agencies.

RAU receives referrals from various sources, such as citizens, providers, and local Departments of Social Services. In SFY 2015, RAU investigated 1,801 referrals and uncovered a total of $5,900,779 in improper payments. In order to supplement the excellent investigative work conducted by RAU staff, DMAS engaged a contractor in SFY 2015 to conduct 400 investigations of Medicaid recipients. These investigations identified a total of $2,060,980 in improper payments. During SFY 2015, 42 individuals were convicted of fraudulently obtaining benefits and ordered to pay $420,639 in restitution. These recipients also are banned from the Medicaid program for one year (the maximum time allowed under federal law), and can be subject to jail time as well.

DMAS is participating in the CMS-mandated Medicaid & CHIP Eligibility Review Pilots which consist of four rounds of reviews designed to test the new eligibility system and case worker actions as they relate to the new MAGI eligibility determination methodology.

Identifying Out-of-State Recipients through Federal PARIS Matches

Public Assistance Reporting Information System (PARIS) is a computer matching system administered by the federal government that provides states with information about individuals who are enrolled in multiple State Medicaid programs. Beginning in July of 2013, the DMAS RAU established a unit dedicated to investigating these cases to determine if the individuals were improperly enrolled in Virginia Medicaid. In SFY 2015, this unit investigated 580 cases and identified overpayments totaling $424,424. In addition to identifying overpayments, disenrolling these individuals prevents future improper payments from being made.

Provider Audits

The Program Integrity Division (PID) staff and contractors focus on provider audits. These audits generally examine a selection of claims filed during prior fiscal years to ensure the claims were filed in accordance with DMAS and Medicaid policy. Generally, these audits involve examining medical records to ensure that the record exists, supports the claim as billed, and is completed in accordance with DMAS policies. In addition, some audits may examine the credentials of the servicing provider to ensure they are qualified to provide the service that was billed. Contractors play an integral role in provider auditing, supplementing staff audits and providing knowledge and expertise in identifying audit targets and conducting reviews. As shown in the table below, during SFY 2015 provider audit activities, DMAS and its contractors identified over $22.2 million in overpayments to Medicaid providers

	SFY 2015 Total Audits	SFY 2015 Overpayments
DMAS - Provider Review Unit	44	$3,418,039
DMAS - Mental Health	37	$1,692,068
DMAS - Hospital	46	$1,675,585
PID Audit Total	**127**	**$6,785,692**
Xerox - Pharmacy & DME (CY 2014)	51	$2,584,304
Health Management Systems - Hospital DRG	92	$6,394,998
Health Management Systems - Behavioral Health	70	$1,333,219
Myers & Stauffer - Physicians & Waiver Services (CY 2014)	338	$5,112,608
Contractor Audit Total	**551**	**$15,425,129**
Total, PID and Contractor Audits	**678**	**$22,210,821**

Provider Audit Highlights

Increased Recoveries - The Provider Review Unit identified over $3.4 million in recoveries during its 2015 audit activities. This represents a 54 percent increase in recoveries over SFY 2014.

Predicting Retractions – Health Management Systems, the contractor who administers the Hospital DRG and Behavioral Health contracts, is moving towards a more advanced claims selection process that will use past audit results to predict retractions. This analysis allows the contractor to focus on claims that are likely to contain the largest amount of recoverable overpayments. Utilizing this approach for the SFY 2015 DRG reviews resulted in a 12.6 percent average increase in identified recoveries per review, for a total estimated impact of more than $720,000 in increased recoveries for that contract.

Collaboration in Behavioral Health – In January 2014, DMAS began to utilize a behavioral health services administrator (BHSA). As a result, PID staff and the BHSA often receive some of the same complaints from the Department of Behavioral Health and Developmental Services (DBHDS). In order to provide a more collaborative approach to investigating these complaints, PID and BHSA staffs are working to conduct joint audits of providers. The goal of this effort is to improve communication between DMAS, the BHSA, and state licensing staff at DBHDS. Planned monthly meetings involving these groups as well as behavioral health policy staff at DMAS will facilitate this collaboration.

Payment Suspension

Some DMAS audits uncover evidence that a provider has made an intentional misrepresentation in order to receive payment to which they are not entitled, otherwise known as fraud. Federal regulations (42 CFR § 455.23) direct states to suspend payments to providers in cases where there exists a "credible allegation of fraud". DMAS has worked with the MFCU to identify credible fraud allegations and implemented processes to block payment to those providers in the DMAS claims payment system. By implementing this process, DMAS is able to prevent additional payments from being made to fraudulent providers during the investigation and prosecution of their fraudulent activities.

Recovery Audit Contractor

As mandated by federal law, since early SFY 2013, DMAS has utilized a Recovery Audit Contractor (RAC) to audit payments to Medicaid providers. RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they identify and collect from providers. As of April 30, 2015, DMAS has received $228,258.20 in payments from providers based on audits conducted under the RAC contract. In addition, DMAS has allowed $349,176.65 in provider adjustments for rebilling of erroneous claims, for a total of more than $570,000 in savings and recoveries.

Medicaid Fraud and Abuse Detection System

Fraud and abuse in Medicaid diverts funds that could otherwise be used for legitimate health care services. DMAS is committed to the continuous improvement of its PI tools to contain costs, reduce inaccurate or unauthorized claims and reimbursement, and better detect fraud and abuse. As a result, in July 2013, DMAS awarded the Medicaid Fraud and Abuse Detection (MFAD) system contract to Health Management Systems (HMS). Over the last two years, the MFAD has analyzed approximately $320 million dollars in claims to identify billing errors, claims processing errors, and misalignment of payment policies. In addition, the contractor has supplied Provider Scorecarding, which assigns risk scores to a number of metrics that are associated with the provider ranking providers based on FWA vulnerabilities. Metrics utilized include the provider's claim billing history as well as their behavior as it relates to FWA and their peers. The contractor also performed a Geospatial analysis through an application that reviews the claims data and plots the distance between the provider and the Medicaid member to identify instances where a specific mileage threshold is exceeded. This analysis provides leads for potential audits by identifying billings that appear suspicious.

Prosecuting Fraud

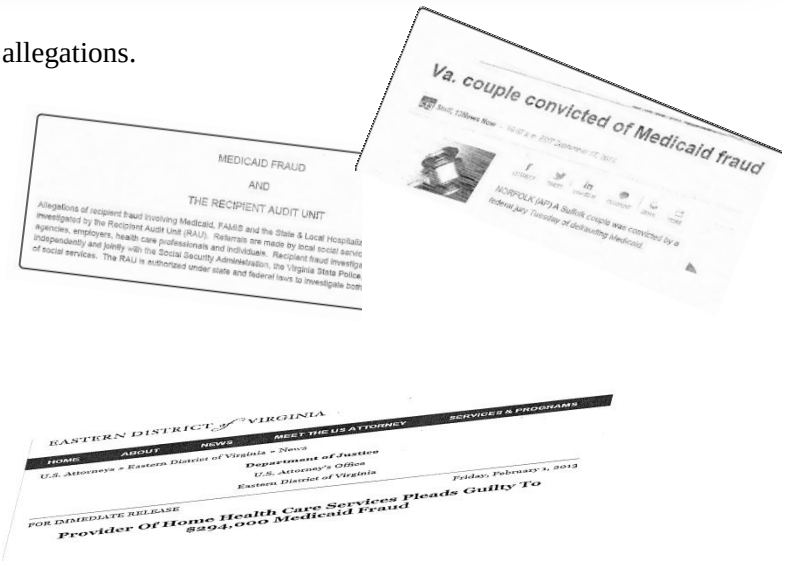
In addition to identifying improper payments, audits conducted by DMAS and its contractors may uncover evidence of potential fraud. Medicaid fraud is a criminal act that occurs when a Medicaid provider or recipient intentionally misrepresents themselves in order to receive an unauthorized benefit. Pursuant to federal law, Virginia's Medicaid Fraud Control Unit (MFCU) was established as a division of the Office of the Attorney General in 1982, and works closely with DMAS to investigate and prosecute suspected cases of Medicaid provider fraud. In addition to establishing restitution for past fraudulent activities, fraud convictions play an important role in program integrity more broadly, as convicted providers are banned from Medicaid participation for life.

DMAS refers potential cases of fraud to the MFCU, provides program knowledge to aid in investigations, and, if required, testifies in cases. DMAS has an exceptional working relationship with the MFCU that continues to improve through constant communication and collaboration, including monthly meetings between staff of the two agencies, and the MFCU's participation in quarterly program integrity collaborative meetings with DMAS and its managed care partners. In SFY 2015, MFCU obtained convictions of 45 health care providers, many based on referrals from DMAS. **Those cases resulted in a total of $4,336,450.48 in court-ordered restitution to the Virginia Medicaid program.** In addition, each of these health care providers was barred for life from participating in the Medicaid program. In addition to working on criminal fraud cases, DMAS also aids MFCU civil prosecutions by reviewing records and testifying in national qui tam cases against pharmaceutical manufacturers. MFCU brought in an additional $3.8 million in recoveries from civil settlements.

This chart represents DMAS referrals to MFCU over the last 9 fiscal years. In SFY 2015, DMAS made 140 fraud referrals, 19 of which were accepted by MFCU to be opened as full-scale fraud investigations. 105 referrals are still pending, as MFCU has yet to fully vet those allegations.

$1.4 Million Fraud Prosecution Based on DMAS Referral

Based on a referral from DMAS to the MFCU, W. Wayne Perry, Jr., 56, and his wife Angela Perry, 52, formerly of Suffolk, Virginia, were found guilty by a jury of charges including health care fraud and ordered to pay $1,459.451 in restitution to the Virginia Medicaid program. Mr. Perry was sentenced to 63 months in prison and Mrs. Perry was sentenced to 25 months in prison. Their business, Community Personal Care, a Medicaid home health care services provider personal care and respite care services orchestrated a massive false billing scheme. Over a four year period, they submitted 7,800 fraudulent claims to the Virginia Medicaid program, falsely representing that personal care and respite care services had been provided to 78 Medicaid recipients in the approximate amount of $1.4 million.



Outreach to Stakeholders

Program integrity activities affect a variety of stakeholders and DMAS works diligently to ensure excellent lines of communication remain open with all interested parties. DMAS staff members routinely make presentations or provide training to various provider groups and other state agency staff regarding program integrity efforts and initiatives. This year, the PID director attended the annual meeting of the Medicaid Fraud Control Unit to provide an overview of the processes used to prevent fraud, waste and abuse in Virginia Medicaid. PI staff also presented to Home- and Community-based Services provider groups on how DMAS audits are conducted and the basis for those reviews. In addition, DMAS held a meeting in January 2015 with providers of durable medical equipment to clarify service documentation requirements; discuss areas of provider concern; identify opportunities to improve the current audit process; provider input on manual changes and development of more training opportunities such as webinars related to common issues such as billing miscellaneous codes. As always, whenever major changes to program integrity processes are implemented, DMAS works hard to provide communication and training far in advance of implementation to ensure providers understand these new requirements.

Staff Training

Medicaid fraud, waste and abuse are areas that are constantly expanding and evolving. In order to identify and mitigate the impact of new and emerging schemes, DMAS staff members seek out opportunities to attend a wide variety of trainings on the latest topics in program integrity. One particularly valuable resource for this type of training is the Medicaid Integrity Institute, a collaboration between the Centers for Medicaid and Medicare Services (CMS) and the Department of Justice to provide structured trainings at a facility in Columbia, SC. Program integrity staff members attended several of these trainings in SFY 2015, summaries of which are listed below.

- **Basic Techniques in Medicaid Fraud Detection Program -** Designed to enhance the fundamental investigatory and analytical skills of state Medicaid employees to maximize the effectiveness of program integrity efforts to detect health care fraud, waste, and abuse. Topics included initial review, ongoing analysis and data collection, referral decision-making, and creation of case action plans.
- **Managed Care Seminar -** Course focused on identifying vulnerabilities and recognizing risks in order to detect health care fraud, waste, and abuse in the managed care environment. Presentations addressed questions related to program integrity oversight of managed care organizations including encounter data, dual eligibles, audits, trends, fee for service and managed care, contracts, financials, behavioral health and chemical dependence issues.
- **Program Integrity Fundamentals -** A basic course, designed as an introduction to program integrity functions within state Medicaid units. Agenda included basic information on the Medicaid program, its history, important functions, and processes. Students participated in a variety of learning environments including plenary sessions and facilitated small group discussions about hot topics in fraud, waste, and abuse.
- **Emerging Trends in Medicaid and Medicare –**Designed for experienced state Program Integrity (PI) employees who are familiar with fraud, waste, and abuse issues involving Medicaid and Medicare. Presentations addressed topics including: services paid for by Medicare; issues related to home health, hospice, personal care, laboratory billing, crossover billing tactics, ambulance, DME, and behavioral health; auditing pharmaceutical inventories; and learning strategies from states that work effectively with CMS's Zone Program Integrity Contractors (ZPIC) or Program Safeguard Contractors (PCS).

Program Integrity in Managed Care

The majority of Virginia Medicaid recipients are covered by managed care organizations (MCOs) that receive a contracted monthly rate for each enrolled member, and each MCO is responsible for paying providers directly for the medical services incurred by its members. The MCOs are required to have policies and procedures in place to prevent, detect and investigate allegations of fraud, waste and abuse. **Through the first three quarters of SFY 2015, MCO program integrity activities avoided or recovered more than $1.29 billion including $1.24 billion in prevented payments for things such as non-covered services, ineligible recipients, and improper claims. $12.1 million of this was from Special Investigations Unit activity and vendor audits alone, which is similar to the activities conducted by PID staff and contractors.**

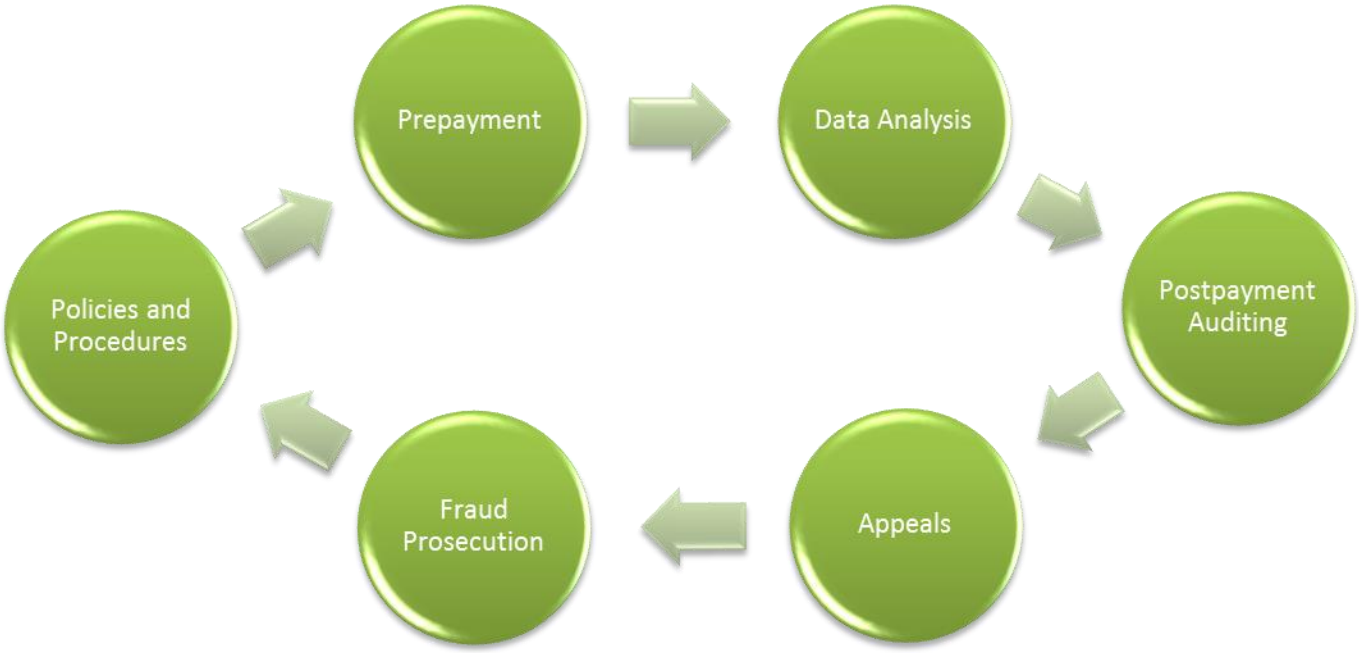
Collaboration is Key

DMAS continues to hold quarterly Managed Care Program Integrity Collaborative meetings where program integrity staffs from the MCOs and DMAS share information about PI issues they identified. It provides a forum to identify problematic providers as well as fraudulent schemes and trends. Plans can share successful approaches to mitigate and avoid these wasteful practices and ensure that all managed care partners are aware of program integrity best practices. In addition, MFCU representatives attend these meetings and provide updates on the status of their fraud investigations. The Collaborative also provides the plans with an opportunity to discuss potential fraud referrals with MFCU investigators and identify audit approaches that will strengthen those referrals.

Program Integrity Compliance Audit

Each year, DMAS conducts an audit of each MCO's compliance with the program integrity requirements under the MCO contract called the Program Integrity Compliance Audit (PICA.) The 2015 PICA review focused on the annual monitoring and audit plans that outline the planned program integrity activities of each MCO. DMAS reviewed the plans submitted by each of the MCOs to ensure that they provided a complete overview of all efforts to prevent, detect and recover improper payments, and to ensure that those efforts represented a coordinated approach to PI.

Continuous Process Improvement through Feedback



DMAS works hard to ensure continuous process improvement by utilizing the results of program integrity activities to identify ways to enhance future efforts. Generally, this feedback is used to hone similar program integrity activities in the future, but it can also result in process changes that shift from pay-and-chase to a more prevention-based model. For example, prepayment controls can be implemented to prevent improper billing practices identified through postpayment audits. This can take the form of placing new claims edits in the payment system, requiring service authorization on service types where audits show improper billing, and updating policies and regulations to more clearly identify proper utilization and billing practices.

Examining the results of prior audits can improve provider selection and concentrate future efforts on areas likely to yield the greatest results. Auditors also can learn from provider appeals results and ensure that future audits focus on areas of review that have solid legal foundation, which is particularly important when auditing in new areas. In the area of fraud detection and prevention, DMAS works with the MFCU to understand the elements that are necessary to ensure successful prosecution of fraud cases. Policies can be clarified and audit practices can be adjusted to produce stronger cases against providers who commit fraudulent acts.

Highlight

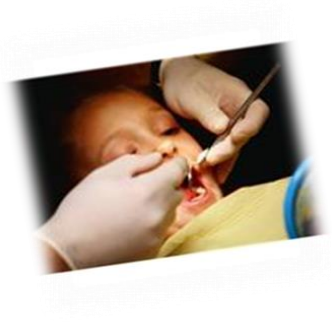
Improving Audit Findings – The behavioral health contract auditor saw a substantial reduction in appeals down from 27% appealed in FY 2014 to only 7% appealed in FY 2015. From "lessons learned" in past audits, the contractor provided a more detailed explanation of their findings to the Agency and recommended changes, along with stakeholder input, which assisted with implementing changes in services via emergency regulations. In addition, there was a higher percentage of validity between the overpayment amount and the revised overpayment amount once additional documentation was submitted to mitigate retractions. As a result, overpayments amounts decreased and providers chose not to appeal these smaller amounts.

Conclusion

The combined program integrity efforts of DMAS and its program integrity partners identified and/or prevented over $186 million in improper expenditures in the Virginia Medicaid program in SFY 2015. The vast majority of these dollars ($145 million) were savings from prepayment activities, particularly the denial of medically unnecessary services through service authorization. Audits of providers and recipients uncovered another $27.6 million in improper payments during SFY 2015. Contract auditors play a large role in the DMAS PI process and DMAS continually evaluates these contracts to identify opportunities for enhancement through the development of new focus areas and deliverables.

DMAS has fostered a collaborative approach with its program integrity partners through monthly meetings with the Medicaid Fraud Control Unit as well as the quarterly Managed Care Program Integrity Collaborative. The collaborative has become a national model and has already helped to create an open and cooperative approach to PI in Virginia Medicaid across all payers. DMAS has worked vigilantly to stamp out fraud, resulting in criminal convictions of 28 Medicaid recipients and 45 Medicaid providers and over $4.7 million in court-ordered fines, penalties, and restitution to the Virginia Medicaid program in SFY 2015.

As we move forward, DMAS will continue to find ways to further ensure the integrity of the Medicaid program, and will remain vigilant in preventing and identifying fraud, waste and abuse.



VIRGINIA'S MEDICAID PROGRAM

DMAS

INNOVATION · QUALITY · VALUE

"Providing a system of high quality and cost effective health care services to qualifying Virginians and their families"